

Overview

The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) is to build resilience and facilitate recovery for people with or at risk for substance use and/or mental disorders. In 2001, SAMHSA created a matrix management system that outlines and guides the agency's activities in pursuit of this mission. The matrix includes 11 program priority areas, one of which addresses the unique needs of older adults with or at risk for mental and/or substance use disorders. The matrix also includes a set of cross-cutting principles, including one recognizing the critical need for data for performance measurement and management. SAMHSA is in the process of developing and implementing a data strategy in order to measure the agency's success in meeting its mission. The National Outcome Measures (NOMs) is a key component of the data strategy. The NOMs have introduced a set of 10 measurable outcomes for three areas: mental health services, substance abuse treatment, and substance abuse prevention. As part of this effort, SAMHSA's activities and data have been reviewed to determine what outcomes could be measured for each NOMs domain.

The highlights contained here represent the best summary information about NOMs currently available from national-level SAMHSA data sets for the older adult program priority area. Since this is a preliminary overview, these national-level data are used to describe possible baselines or starting points from which to measure changes in the future. These baseline data on the older adult population are available for 7 of the 10 NOMs domains: Reduced Morbidity, Employment/Education, Stability in Housing, Access/Capacity, Retention, Perception of Care, and Use of Evidence-Based Practices. Further work is under way to identify potential data sources for use as measures of outcomes for the remaining domains.

SAMHSA's Action Plan for the older adult program priority area is available at http://www.samhsa.gov/Matrix/SAP_older.aspx.

National Outcome Measures Overview

SAMHSA has developed these 10 NOMs domains in collaboration with the States. These domains are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities. The development and application of NOMs is a key component of the SAMHSA initiative to set performance targets for State and Federally funded initiatives and programs for substance abuse prevention and mental health promotion, early intervention, and treatment services. The NOMs domains and their associated outcome measures are as follows:

- Reduced Morbidity (for substance abuse—abstinence from drug/alcohol use, including decreased use of substances of abuse, nonuser stability, increasing perceived risk, increasing disapproval, increasing age of first use; for mental health—decreased mental illness symptomatology)
- Employment/Education (getting and keeping a job; workplace drug and alcohol policy; alcohol, tobacco, and other drug school suspensions and expulsions; or enrolling and staying in school)
- Crime and Criminal Justice (decreased criminality, incarcerations, and alcohol-related car crashes and injuries)
- Stability in Housing (increased stability in housing)
- Social Connectedness (family communication about drug use, increasing social supports and social connectedness)
- Access/Capacity (increased access to services/increased service capacity)
- Retention (for substance abuse—increased retention in treatment, access to prevention messages, evidence-based programs/strategies; for mental health—reduced utilization of psychiatric inpatient beds)
- Perception of Care (or services)
- Cost Effectiveness
- Use of Evidence-Based Practices

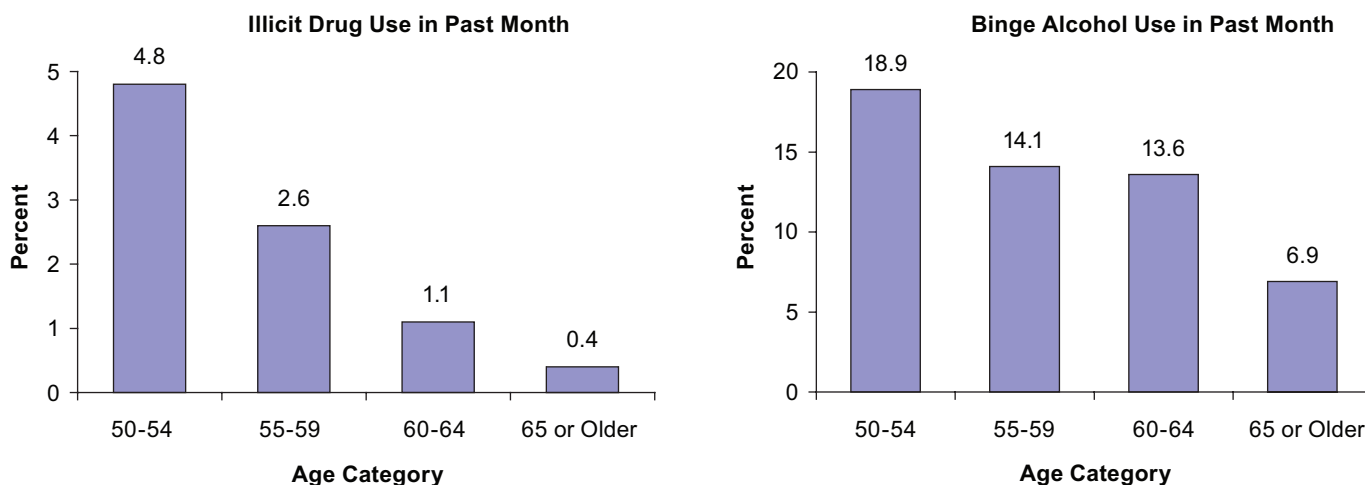
SAMHSA recognizes that there are challenges to critically examining the NOMs in the older adults program priority area. One basic challenge is how to define measures of success for the older adult population given the more than 40-year span involved. For NOMs domains such as employment and housing, outcomes appropriate for those aged 50 to 60 are likely to be different than outcomes for those aged 75 or older.

Another challenge in using SAMHSA data sets is limitations in the data available for specific ages. The National Survey on Drug Use and Health (NSDUH) collects individual ages, but frequently collapses data on older adults to the category 50 or older, or, in some cases, to four older age categories—50 to 54, 55 to 59, 60 to 64, and 65 or older—because of small sample sizes. It may be possible to report on individual ages for some topics. Work is underway to use the analytic file to look at data related to alcohol use for individual ages among older adults, as there are likely to be enough respondents to report accurate estimates. Reporting of illicit drug use among older adults, however, may not yield accurate estimates due to small sample sizes. The Treatment Episode Data Set (TEDS) also collects individual ages, so analysts are not limited to the age categories published in TEDS reports; however, it must be noted that TEDS data come primarily from substance abuse treatment facilities that receive some public funding.

The major source of mental health reporting for SAMHSA's Center for Mental Health Services (CMHS) is the Uniform Reporting System (URS) which consists of data collected voluntarily by the States. The older adult age categories URS reports are 65 or older and sometimes 65 to 74 and 75 or older. Thus, while data relevant to overall NOMs outcomes are collected, the data may not be in a form useful for examining NOMs outcomes for the older adult population. In addition, these data tend to have large ranges in the values reported because of important variations in State data systems, reporting capacity, means of instrumentation, data collection methods, and variable definitions, as well as in the number of States reporting any data for a specific variable. In addition, the URS data set represents only individuals who have been seen through a publicly funded mental health system served by the State Mental Health Authority. The URS data set does not include individuals seen by private providers or individuals receiving their mental health services from other agencies such as the criminal and juvenile justice systems, homeless programs, and child welfare. However, CMHS is working with an external expert panel to develop a plan to refine their data and expand their data sets.

At this time, SAMHSA is striving to develop more in-depth and comprehensive data and to fine-tune strategies to effectively collect data on older adults. It is also making continuous efforts to elaborate the definitions of the outcomes. As SAMHSA refines and implements the data strategy for performance measurement and management, additional NOMs data for older adults will be developed.

Figure 1. Percent of Older Adults Reporting Illicit Drug Use or Binge Alcohol Use in Past Month, by Age Category: 2004



See notes at end.

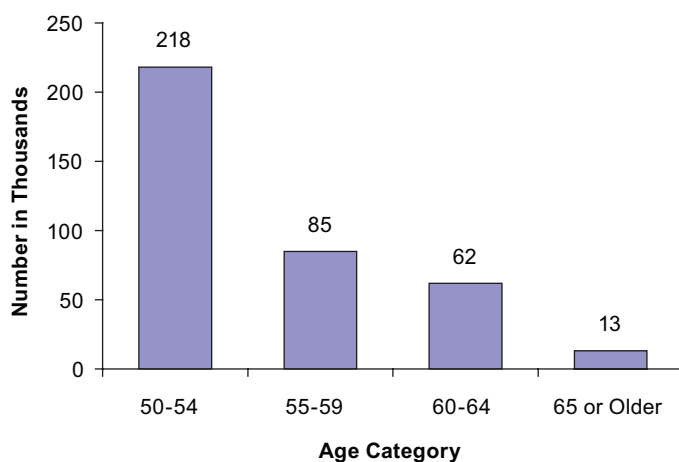
Source: SAMHSA, OAS, 2004 NSDUH [Tables 1.19B, 2.25B].

Substance Abuse Prevention NOMs for Older Adults

Within the substance abuse prevention area, NOMs for older adults are available from SAMHSA's national-level data sets under the Abstinence from Drug/Alcohol Use domain. These data come from the 2004 NSDUH¹ and show that although substance abuse and dependence declined with age, a measurable percentage of older adults were still abusing substances. Figure 1 shows that both illicit drug use and binge alcohol use remained a problem, even among adults 65 or older.

For the remaining NOMs prevention domains (Employment/Education, Crime and Criminal Justice, Access/Capacity, Retention, Social Connectedness, Cost Effectiveness, and Use of Evidence-Based Practices), information specific to the older adult population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the older adult population cannot be reported from SAMHSA's national-level data sets.

Figure 2. Number of Older Adults Who Needed But Did Not Receive Treatment for an Illicit Drug Problem at a Specialty Facility in the Past Year, by Age Category: 2004



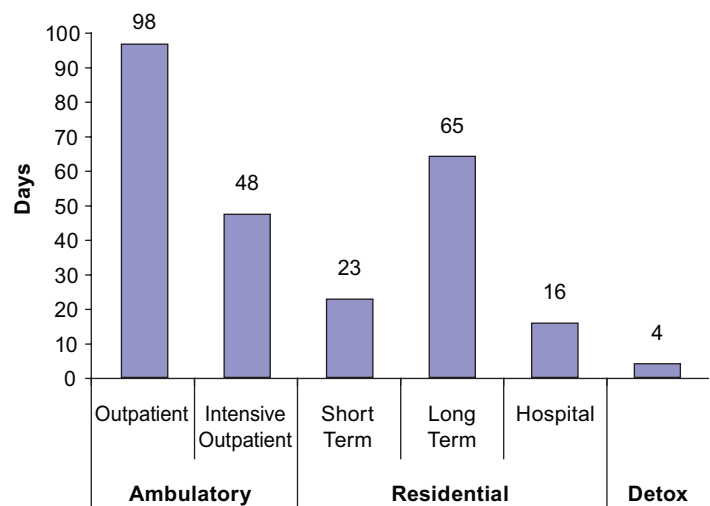
See notes at end.
Source: SAMHSA, OAS, 2004 NSDUH [Table 5.72A].

Substance Abuse Treatment NOMs for Older Adults

For substance abuse treatment, national-level data are available for older adults under the Access/Capacity and Retention domains. NSDUH¹ provides estimates of the penetration rate, one of the access/capacity measures, while data for one of the retention measures—length of stay—are provided by TEDS.² In 2004, about 378,000 adults aged 50 or older needed, but did not receive, treatment for an illicit drug problem (Figure 2). In 2003, the median length of stay for older adult discharges who completed their treatment varied by the type of service received: within ambulatory services, the median length of stay for outpatient care was 98 days and for intensive outpatient care 48 days; within residential services, median lengths of stay were 16 days for hospital care, 23 days for short-term care, and 65 days for long-term care; and the median length of stay for those completing detoxification services was 4 days (Figure 3).

Data on outcomes for four of the substance abuse treatment domains (Abstinence from Drug/Alcohol Use, Employment/Education, Crime and Criminal Justice, and Stability in Housing) will be available when the State Outcomes Measurement and Management System (SOMMS) data set is fully implemented in fiscal year (FY) 2008. For the remaining substance abuse treatment domains (Social Connectedness, Perception of Care, Cost Effectiveness,

Figure 3. Median Length of Stay for Discharges Aged 50 to 96 Who Completed Substance Abuse Treatment, by Type of Service: 2003



See notes at end.
Source: SAMHSA, OAS, 2003 TEDS [Data file—discharge data not released; for SAMHSA internal use only].

and Use of Evidence-Based Practices), information specific to the older adult population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the older adult population cannot be reported from SAMHSA's national-level data sets.

Mental Health Services NOMs for Older Adults

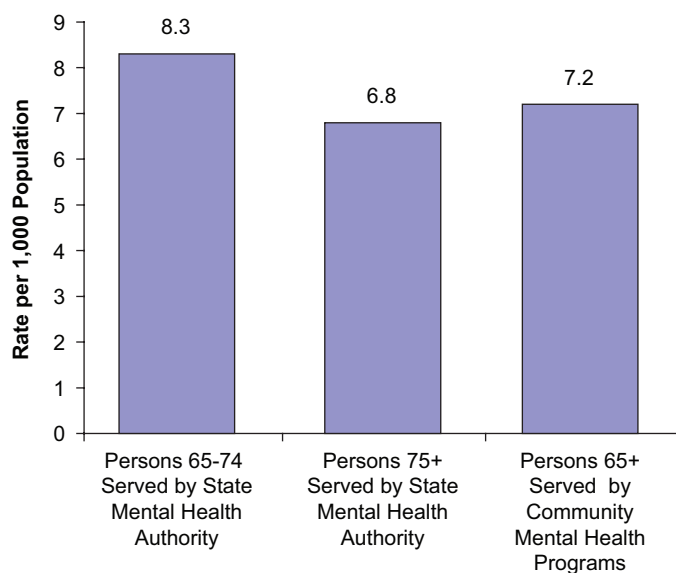
National-level mental health services data are available for 6 of the 10 domains (Employment/Education, Stability in Housing, Access/Capacity, Reduced Utilization of Psychiatric Inpatient Beds, Perception of Care, and Use of Evidence-Based Practices). Most data are from URS,³ but NSDUH¹ provides some Access/Capacity data and the Perception of Care data. About 152,800 of those served by a State mental health authority were 65- to 74-year-olds and another 117,200 were aged 75 or older, and community mental health programs served about 243,200 adults aged 65 or older. The rates of these older adults served per 1,000 population are shown in Figure 4. Of those aged 50

or older in 2003 who had past year serious psychological distress and received treatment for a mental health problem, 52.2 percent perceived a great deal or a lot of help from the treatment.⁴

State mental health agencies reported that 28.0 percent of mental health consumers aged 65 or older were employed, and 51.4 percent were living in private residences (Figure 5). Only 16.0 percent of 65- to 74-year-olds were readmitted within 180 days of discharge (Figure 6). The penetration rates of three measures of evidence-based practices—assertive community treatment, supported employment, and supported housing—ranged from 3.0 percent to 3.8 percent for 65- to 74-year-olds and from 0.7 percent to 2.4 percent for those aged 75 or older (Figure 7).

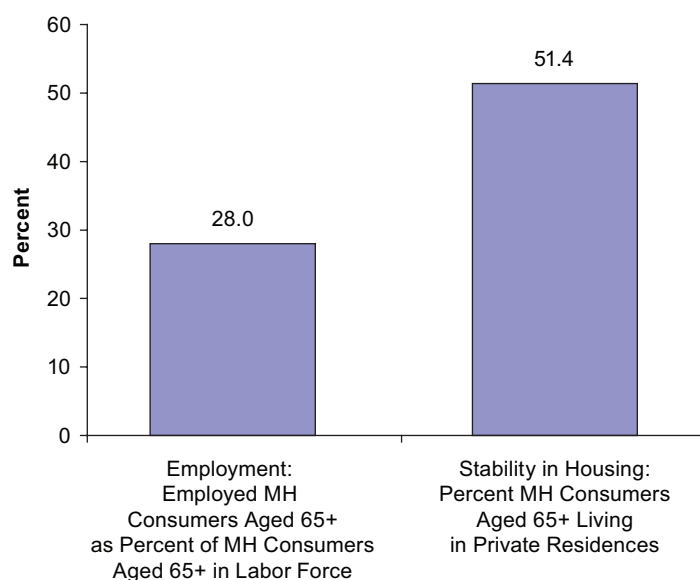
For the remaining mental health services domains (Decreased Mental Illness Symptomatology, Crime and Criminal Justice, Social Connectedness, and Cost Effectiveness), information specific to the older adult population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the older adult population cannot be reported from SAMHSA's national-level data sets at this time.

Figure 4. Penetration Rate of Older Adults Served by State Mental Health Authorities or Community Mental Health Programs: FY 2004



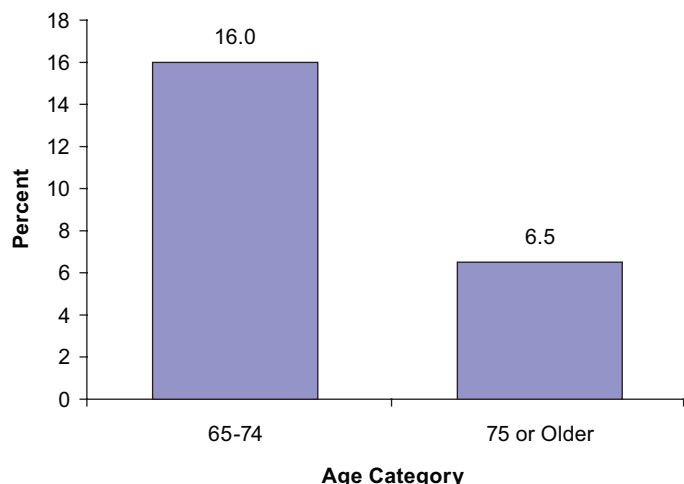
See notes at end.
Source: SAMHSA, CMHS, 2004 URS [Access Domain Tables 1-2].

Figure 5. Percent of Older Adult Mental Health Consumers Who Were Employed or Living in Private Residences: FY 2004



See notes at end.
Source: SAMHSA, CMHS, 2004 URS [Outcomes Domain Table 1, Appropriateness Domain Table 6].

Figure 6. Percent of Older Adult Mental Health Consumers Readmitted within 180 Days to Any Psychiatric Inpatient Bed, by Age Category: FY 2004



See notes at end.
Source: SAMHSA, CMHS, 2004 URS [Outcomes Domain Table 6].

Figure Notes:

Figure 1: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically (NSDUH Table 1.19B). Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days (NSDUH Table 2.25B).

Figure 2: Respondents were classified as needing treatment for an illicit drug problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs; (2) abuse of illicit drugs; or (3) received treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically (NSDUH Table 5.72A).

Figure 3: These are preliminary estimates based on data from the 26 States or jurisdictions that had linked discharge to admission records for 2003. The service categories exclude records where methadone treatment was planned (TEDS data file).

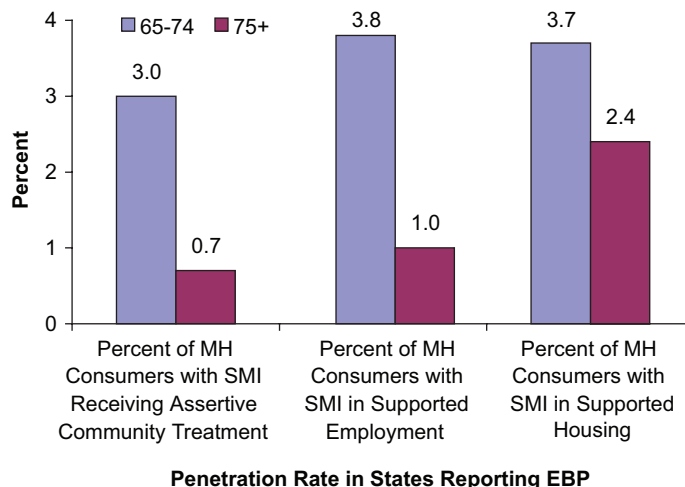
Figure 4: State mental health authority data for 65- to 74-year-olds were reported by 56 States or jurisdictions and for those aged 75 or older by 54 States or jurisdictions (URS Access Domain Table 1). Community mental health program data were reported by 53 States or jurisdictions for those aged 65 or older (URS Access Domain Table 2).

Figure 5: Employment data for 65 or older were reported by 42 States or jurisdictions, and housing data were reported by 39 States or jurisdictions (URS Outcome Domain Table 1 and Appropriateness Domain Table 6).

Figure 6: Retention data for 65- to 74-year-olds were reported by 13 States or jurisdictions and for those aged 75 or older by 10 States or jurisdictions (URS Outcomes Domain Table 6).

Figure 7: The penetration rates are based on the percentage of mental health consumers receiving the evidence-based practice out of all the adults in the same age category with serious mental illness. Data includes only States or jurisdictions reporting evidence-based practices. Assertive community treatment data for 65- to 74-year-olds

Figure 7. Percent Older Adult Mental Health Consumers with Serious Mental Illness (SMI) Participating in Selected Evidence-Based Practices (EBP), by Age Category: FY 2004



See notes at end.
Source: SAMHSA, CMHS, 2004 URS [Appropriateness Domain Tables 8-10]

were reported by 20 States or jurisdictions and for those aged 75 or older by 17 States or jurisdictions (URS Appropriateness Domain Table 8). Supported employment data for 65- to 74-year-olds were reported by 19 States or jurisdictions and for those aged 75 or older by 11 States or jurisdictions (URS Appropriateness Domain Table 9). Supported housing data for 65- to 74-year-olds were reported by 19 States or jurisdictions and for those aged 75 or older by 16 States or jurisdictions (URS Appropriateness Domain Table 10).

References:

1. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). *2004 National Survey on Drug Use and Health: Detailed tables* (Tables 1.19B, 2.25B, 5.72A, 6.25B). Retrieved January 17, 2006, from <http://www.oas.samhsa.gov/NSDUH/2k4nsduh/2k4tabs/toc.htm#TopOfPage>.
2. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *2003 Treatment Episode Data Set* [file of data received through September 14, 2005—discharge data not released; for SAMHSA internal use only].
3. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2005). *2004 CMHS Uniform Reporting System output tables* (Access Domain Tables 1-2, Appropriateness Domain Tables 6, 8-10, Outcomes Domain Tables 1 and 6). Retrieved January 13, 2006, from <http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2004.asp>.
4. Respondents were asked how much the counseling or medicine they received in the past year improved their ability to manage daily activities. Respondents with missing information were excluded. Mental Health Treatment/Counseling is defined as having received inpatient care, outpatient care, or using prescription medication for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded (*National Survey on Drug Use and Health: Detailed tables*, Table 6.25B). Retrieved January 17, 2006, from <http://www.oas.samhsa.gov/NSDUH/2k4nsduh/2k4tabs/toc.htm#TopOfPage>.